TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
OBI National Insurance Co

MFDR Tracking Number
M4-17-3023-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
June 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $1,150.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19 – 23, 2016	Physical Therapy Services	$1,150.44	$811.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of physical therapy services rendered between September 19, 2016 and September 23, 2016. The explanation of benefits provided with the medical fee dispute lists explanation code 18 – "Exact duplicate claim/service."

   Review of the submitted information found insufficient evidence to support these dates of service were either paid or denied. Therefore, the carrier's denial is not supported. The dates of service in question will be reviewed per applicable fee guideline.

2. 28 Texas Administrative Code §134.203 (b) and (c) state in pertinent parts,

   (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The applicable Medicare payment policy regarding therapy services is detailed at www.cms.gov, in the Claims Processing Manual, 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, *Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.*

   Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

   Full payment is made for the unit or procedure with the highest PE payment.

   For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

   The maximum allowable reimbursement for the services in dispute is calculated below:

Date of Service Submitted Code	Physician Fee Schedule Allowable	Practice Expense	Work Expense (Full Payment)	Malpractice Expense (Full payment)	50 per cent of PE	Total	Units	MAR (DWC Conversion Factor/Medicare Conversion Factor) x Allowable
September 19, 2016 97110	$32.95	0.44	.46 x 32.95 = $15.16	0.02 x 32.95 = 0.66	0.44 x 32.95 x 50% = $7.25=	$15.16 + $0.66 + $7.25 = $23.07	$23.07 x 4 = $92.28	56.82/35.8043 x 92.28 = $146.44
September 19, 2016 97140	$30.44	0.4	.44 x 30.44 = $13.39	0.01 x 30.44 = $0.30	0.4 x 30.44 x 50% = $6.09	$13.39 + $0.30 + $6.09 = $19.78	$19.78 x 2 = $39.56	56.82/35.8043 x 39.56 = $62.78
September 19, 2016 97112	$34.39	**0.48 Highest Practice Expense**					1	56.82/35.8043 x $34.39 = $54.58
September 19, 2016 G0238	$14.11	0.2	0.184 x 14.11 = $2.60	0.01 x $14.11 = $0.14	0.2 x 14.11 x 50% = $1.41	$2.60 + $0.14 $1.41 = $4.15	1	56.82/35.8043 x $4.15 = $6.58
September 21, 2016 97110	$32.95	0.44	.46 x 32.95 = $15.16	0.02 x 32.95 = 0.66	0.44 x 32.95 x 50% = $7.25=	$15.16 + $0.66 + $7.25 = $23.07	$23.07 x 4 = $92.28	56.82/35.8043 x 92.28 = $146.44
September 21, 2016 97140	$30.44	0.4	.44 x 30.44 = $13.39	0.01 x 30.44 = $0.30	0.4 x 30.44 x 50% = $6.09	$13.39 + $0.30 + $6.09 = $19.78	$19.78 x 2 = $39.56	56.82/35.8043 x 39.56 = $62.78
September 21, 2016 97112	$34.39	**0.48**					1	56.82/35.8043 x $34.39 = $54.78
September 21, 2016 G0283	$14.11	0.2	0.184 x 14.11 = $2.60	0.01 x $14.11 = $0.14	0.2 x 14.11 x 50% = $1.41	$2.60 + $0.14 $1.41 = $4.15	1	56.82/35.8043 x $4.15 = $6.58
September 23, 2016 97110	$32.95	0.44	.46 x 32.95 = $15.16	0.02 x 32.95 = 0.66	0.44 x 32.95 x 50% = $7.25=	$15.16 + $0.66 + $7.25 = $23.07	$23.07 x 4 = $92.28	56.82/35.8043 x 92.28 = $146.44
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							Total	$811.54

3. The total allowable reimbursement for the services in dispute is $811.54. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $811.54. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $811.54

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable) the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $811.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		August 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.